MDR Tracking Number: M5-04-1450-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on January 23, 2004.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. The mechanical traction, therapeutic exercises, unlisted therapeutic procedures, therapeutic activities, electrical stimulation, ultrasound, office visit, manual therapy techniques, chiropractic manipulation test 1-5 regions, prolonged physical service, therapeutic procedures, electrical stimulation unattended from 05-20-03 through 09-30-03 **were** found to be medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On April 15, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
05-20-03	97250 97032 97124 97012 97139 97139	$48.00 $27.00 $33.00 $40.00 $100.00 $100.00	$0.00	O O O O M M	$43.00 $22.00 $28.00 $20.00 DOP DOP	1996 MFG 133.307(e)(2)(A)	The requestor did not submit recon HCFA's for services rendered on 05-20-03 in accordance with rule 133. 307(e)(2)(A). Therefore, reimbursement is not recommended.
05-30-03	97032 97012 97139 97139 99213	$27.00 $40.00 $100.00 $100.00 $60.00	$0.00	O O O O O		1996 MFG 133.307(e)(2)(A)	The requestor did not submit recon HCFA's for services rendered on 05-30-03 in accordance with rule 133. 307(e)(2)(A). Therefore, reimbursement is not recommended.

08-12-03	97750 97750	$100.00 $100.00	$0.00	N N	$36.94 each 15min	Medicare Fee Schedule Rule 133.307(e)(2)(A)	The requestor did not submit recon HCFA's for services rendered on 08-12-03 in accordance with rule 133. 307(e)(2)(A). Therefore, reimbursement is not recommended.
09-09-03	98910	$40.00	$0.00	U	$40.00	Medicare Fee Schedule	In accordance with 134.202(b): for billing, reporting, and reimbursement of professional medial services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies. The requestor did not bill the correct CPT code applicable at the time services were rendered therefore, no reimbursement is recommended.
TOTAL		$915.00					The requestor is entitled to reimbursement of $0.00.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and/or in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 05-20-03 through 09-30-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 5th day of November 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

October 29, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1450-01
IRO Certificate #: 5348

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ___. The diagnoses for this patient have included sprain of unspecified site of shoulder and upper arm, displacement of cervical intervertebral disc without myelopathy, and brachial neuritis or radiculitis NOS. An MRI scan of the cervical spine on 3/26/03 showed spinal stenosis at C6-7 from disc protrusion with a broad disc with greater eccentricity on the right, spinal stenosis at C5-6 and to a lesser degree disc protrusion with foraminal narrowing at this level bilaterally, and a disc bulge at C3-4 and protrusion at C4-5 that is mildly narrowing the spinal canal. An EMG/NCV dated 6/6/03 indicated evidence of a lumbosacral radiculopathy, most severe at left L5-S1. Treatment for this patient's condition has included cervical epidural steroid injections, 3, mechanical traction, therapeutic exercises and procedures, electrical stimulation, ultrasound and therapeutic activities.

Requested Services

Mechanical traction, therapeutic exercises, unlisted therapeutic procedures, therapeutic activities, electrical stimulation, ultrasound, office visit, manual ther tech, chiro man test-1-5 regions, prolonged phys serv, ther proc, electrical stimulation unattended from 5/20/03 through 9/30/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his shoulder, upper arm, and cervical spine on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient have included sprain of unspecified site of shoulder and upper arm, displacement of cervical intervertebral disc without myelopathy, and brachial neuritis or radiculitis NOS. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included cervical epidural steroid injections, 3, mechanical traction, therapeutic exercises and procedures, electrical stimulation, ultrasound and therapeutic activities. The ___ chiropractor reviewer explained that the patient made progress with the treatment rendered. The ___ chiropractor reviewer also explained that due to the patient's injury and pain syndrome, slow progress would be expected. Therefore, the ___ chiropractor consultant concluded that the mechanical traction, therapeutic exercises, unlisted therapeutic procedures, therapeutic activities, electrical stimulation, ultrasound, office visit, manual ther tech, chiro man test-1-5 regions, prolonged phys serv, ther proc, electrical stimulation unattended from 5/20/03 through 9/30/03 were medically necessary to treat this patient's condition.

Sincerely,